Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 16, 2017

Ms. Brenda Egbert, Manager
Bradford Oasis
92 Cottage Street
Bradford, VT 05033-8897

Dear Ms. Egbert:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 19, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

OCT 1 0 2017

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	C 09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD OASIS	92 COTTAGE STREET BRADFORD, VT 05033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite complaint investigation was completed on 9/18/17 by the Division of Licensing and Protection. The findings include the following:	R100	Please see attached plans of correction.	
R146 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that direct care staff were provided instruction and supervision to adequately treat 1 applicable resident, at the time the resident was having difficulty breathing with documentation identifying low oxygen saturation levels (Resident #1). The findings include the following: On 4/3/17 between the hours of 3-10 PM, staff notes written by the Patient Care Attendant (PCA), identify that the Resident #1 "complained a lot of not getting enough oxygen". The PCA checked his/her oxygen saturation level that registered at 83%. The resident stated, "it is too low" and the PCA explained, "it was OK, it has been 85% or so, so 83 is not horrible". At this time the resident requested her/his inhaler but the PCA voiced it was not time. The next day the resident requested her/his inhaler again and was denied. On 9/9/17 at approximately 2 PM, the PCA confirmed that the resident did not receive	R146		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Egbert, RN — TITLE — (X6) DATE: 10/8/17

R146 - R224 POC's accepted 10/12/17 mBertrandRN/me

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R146	Continued From page 1 her/his scheduled inhaler or the as needed inhaler. The Medication Administration Record (MAR) for 4/1/17 through 4/4/17, evidences that the inhalers were never administered. There is no documented evidence that the facility Registered Nurse/Manager or the Nurse Practitioner was notified that the resident was having difficulty breathing or registered a low saturation level. Oxygen saturation is a measurement that identifies the percentage of oxygen in the blood. Values under 90% are considered low and result in hypoxia a sign of a problem in breathing or circulation that results in shortness of breath. (Lippincott Manuals of Nursing Practice, Wolters Kluwer Health/Lippincott, Williams and Wilkins p 370.) On 4/4/17 the Nurse Practitioner (NP), was scheduled for a monthly house call. On examination, the resident was diagnosed with an acute exacerbation of chronic obstructive pulmonary disease and an exacerbation of asthma. Resident #1 required the treatment of antibiotics, steroids and the addition of two (2) inhalers. On 9/18/17 at approximately 1:30 PM, the RN confirmed the above documentation is evident in the medical record and that it does not identify that the RN and/or the physician were notified.	R146		
R154 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (11)	R154		

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R154	Continued From page 2 Implement assistive therapy as necessary to maintain or improve the resident's functional status, with consultation from a licensed professional as needed; and This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the Registered Nurse (RN) and/or the attending physician at the time a resident was in need of treatment to improve respiratory function for 1 applicable residents (Resident #1). The findings include the following: On 4/3/17 between the hours of 3-10 PM, staff notes written by the Patient Care Attendant (PCA), identify that the Resident #1 "complained a lot of not getting enough oxygen". The PCA checked his/her oxygen level that registered at 83%. The resident stated "it is too low" and the PCA explained, "it was OK, it has been 85% or so, so 83 is not horrible". At this time the resident requested her/his inhaler but the PCA voiced it was not time. The next day the resident requested her/his inhaler again and was denied. On 9/9/17 at approximately 2 PM, the PCA confirmed that the resident did not receive her/his scheduled inhaler or the as needed inhaler. The Medication Administration Record (MAR) for 4/1/17 through 4/4/17, evidences that the inhalers were never administered. There is no documented evidence that the facility Registered Nurse/Manager or the Nurse Practitioner was notified that the resident was having difficulty breathing or registered a low saturation level. Oxygen saturation is a measurement that identifies the percentage of oxygen in the blood.	R154		

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R154	Continued From page 3 Values under 90% are considered low and result in hypoxia a sign of a problem to breathing or circulation that results in shortness of breath. (Lippincott Manuals of Nursing Practice, Wolters Kluwer Health/Lippincott, Williams and Wilkins p 370.) On 4/4/17 the Nurse Practitioner (NP), was scheduled for a monthly house call. On examination, the resident was diagnosed with an acute exacerbation of chronic obstructive pulmonary disease and an exacerbation of asthma. Resident #1 required the treatment of antibiotics, steroids and a the addition of two (2) inhalers. On 9/18/17 at approximately 1:30 PM, the RN confirmed the above documentation is evident in the medical record and that it does not identify that the RN and/or the physician were notified.	R154		
R155 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility Registered Nurse (RN) failed to assume responsibility for staff performance in the administration of medication with one (1) sampled resident who was having difficulty breathing and with low oxygen saturation level. The RN also	R155		

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R155	Continued From page 4 failed to assume responsibility in monitoring 2 applicable residents, who were not assessed for self-administration of prescription medication left at the bedside for the treatment of chest pain (Resident #1 and #2). The findings include the following: 1. On 4/3/17 between the hours of 3-10 PM, staff notes written by the Patient Care Attendant (PCA), identify that the Resident #1 "complained a lot of not getting enough oxygen". The PCA checked his/her oxygen level that registered at 83%. The resident stated, "it is too low" and the PCA explained, "it was OK, it has been 85% or so, so 83 is not horrible". At this time the resident requested her/his inhaler but the PCA voiced it was not time. The next day the resident requested her/his inhaler again and was denied. On 9/9/17 at approximately 2 PM, the PCA confirmed that the resident did not receive her/his scheduled inhaler or the as needed inhaler. The Medication Administration Record (MAR) for 4/1/17 through 4/4/17, evidences that the inhalers were never administered. There is no documented evidence that the facility Registered Nurse/Manager or the Nurse Practitioner was notified that the resident was having difficulty breathing or registered a low saturation level. Oxygen saturation is a measurement that identifies the percentage of oxygen in the blood. Values under 90% are considered low and result in hypoxia a sign of a problem to breathing or circulation that results in shortness of breath. (Lippincott Manuals of Nursing Practice, Wolters Kluwer Health/Lippincott, Williams and Wilkins p 370.)	R155		

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R155	Continued From page 5 On 4/4/17 the Nurse Practitioner (NP), was scheduled for a monthly house call. On examination, the resident was diagnosed with an acute exacerbation of chronic obstructive pulmonary disease and an exacerbation of asthma. Resident #1 required the treatment of antibiotics, steroids and the addition of two (2) inhalers. On 9/18/17 at approximately 1:30 PM, the Registered Nurse confirmed the above documentation is evident in the medical record and that it does not identify that the RN and/or the physician were notified. 2. Per medical record review, Resident #1 has a physician order for Nitroglycerin 0.4 milligrams (mg.) as directed Sublingual (SL) for chest pain, repeat every 5 minutes two times then seek Emergent care after three (3) doses. On 9/18/17 at 11:10 AM, in the presence of the PCA, Resident #1 identified s/he had a bottle of nitroglycerin tablets located in his/her closet. Per inspection of the bottle there were eight (8) tablets present. The resident denies taking any of the pills or having any pain that required self administration. The resident did voice that the Registered Nurse Manager informed her/him to let the staff know if any are taken. Per review of the medical record, there is no evidence that an assessment has been completed to ensure that Resident #1 has the abilities and knowledge to self administer prescription medication left at the bedside. On 9/18/17 at 11:10 AM, the PCA confirms that s/he had no knowledge that the resident had the medication at the bedside.	R155		

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R155	Continued From page 6 Per facility medication protocol the facility will "Assist with medication means helping a resident who is capable of self-administration, to ingest, store and monitor medication". 3. Per medical record review, Resident #2 has a physician order for Nitroglycerin 0 .4 milligrams (mg.) Sublingually as needed for Angina (chest pain). On 9/18/17 at 11:10 AM, in the presence of the PCA, Resident #1 identified s/he had a bottle of nitroglycerin in his/her pocket enclosed in a metal bottle. The bottle of nitroglycerin contains many tablets, has an expiration date of 6/2018 and is covered is dusty green powder. The resident denies having any chest pain or taking any of the tablets. On 9/18/17 at 11:15 AM, the PCA confirms that s/he had no knowledge that the resident had the medication at the bedside. Per review of the medical record, there is no evidence that an assessment has been completed to ensure that Resident #1 has the abilities and knowledge to self administer prescription medication left at the bedside. Per facility medication protocol the facility will "Assist with medication means helping a resident who is capable of self-administration, to ingest, store and monitor medication".	R155		
R170 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R170		

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R170	Continued From page 7 5.10.f Residents who are capable of self-administration have the right to purchase and self administer over-the-counter medications. However, the home must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications without violating the resident's rights to direct the resident's own care. If a resident's over-the-counter medications use poses a significant threat to the resident's health, staff must notify the physician This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility Registered Nurse (RN)/Manager failed to assess and monitor 2 of 2 sampled residents for their abilities for the self administration of prescribed medication that is left at the bedside, used to alleviate chest pain (Resident #1 and Resident #2). The findings include the following: 1. Per medical record review, Resident #1 has a physician order for Nitroglycerin 0.4 milligrams (mg.) as directed Sublingual (SL) for chest pain, repeat every 5 minutes two times then seek Emergent care after three (3) doses. On 9/18/17 at 11:10 AM, in the presence of the PCA, Resident #1 identified s/he had a bottle of nitroglycerin tablets located in his/her closet. Per inspection of the bottle, there were eight (8) tablets present. The resident denies taking any of the pills or having any pain that required the self administration. The resident did voice that the RN/Manager informed her/him to let the staff know if any are taken.	R170		

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R170	Continued From page 8 Per review of the medical record, there is no evidence that an assessment has been completed to ensure that Resident #1 has the abilities and knowledge to self administer prescription medication left at the bedside. On 9/18/17 at 11:10 AM, the PCA confirms that s/he had no knowledge that the resident had the medication at the bedside. 2. Per medical record review, Resident #2 has a physician order for Nitroglycerin 0 .4 milligrams (mg.) Sublingually as needed for Angina (chest pain). On 9/18/17 at 11:10 AM, in the presence of the PCA, Resident #1 identified s/he had a bottle of nitroglycerin in his/her pocket enclosed in a metal bottle. Per inspection of the bottle of nitroglycerin, it was found to contain many tablets, has an out date of 6/2018 and is covered is dusty green powder. The resident denies having any chest pain or taking any of the tablets. Per review of the medical record, there is no evidence that an assessment has been completed to ensure that Resident #1 has the abilities and knowledge to self administer prescription medication left at the bedside. On 9/18/17 at 11:15 AM, the PCA confirms that s/he had no knowledge that the resident had the medication at the bedside. Per facility medication protocol the facility will "Assist with medication means helping a resident who is capable of self-administration, to ingest, store and monitor medication".	R170		

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R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to monitor 1 of 2 sampled residents who receive psychoactive medications. For Resident #1, the findings include the following: Record review for Resident #1, identifies that s/he has received Seroquel since admission on 5/18/15. This medication is classified as an	R171		

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R171	Continued From page 10 antipsychotic medications that is used to treat Schizophrenia, Bipolar Disorder, Dementia and Depression. Side effects that can be caused using this medication are (but not limited to), muscle/nerve problems and Tardive Dyskinesia (a disorder that results in involuntary body movements). Medical record identifies an Abnormal Involuntary Movement Scale (AIMS) evaluation was completed on 2/6/17. On 8/1/17 the Nurse Practitioner has documented that the resident has a "tremor of upper extremities noted bilaterally". Facility policy titled "AIMS Policy-Psychoactive Meds", identifies any resident showing involuntary movements most of the time will be evaluated quarterly. On 9/18/17 the facility Registered Nurse confirms that the last located evaluation was completed on 2/6/17.	R171		
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to ensure that 1 of 2 sampled residents was free from neglectful	R224		

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R224	Continued From page 11 nursing care, resulting in the resident suffering from shortness of breath and increased anxiety (Resident #1). The findings include the following: On 4/3/17 staff notes dated 4/3/17, for Resident #1 identifies that the Registered Nurse (RN) completed a lung assessment which evidenced, "mild diminished bilateral fields". On 4/3/17 between the hours of 3-10 PM, staff notes written by the Patient Care Attendant (PCA), identify that the Resident #1, "complained a lot of not getting enough oxygen". The PCA checked his/her oxygen level that registered at 83%. The resident stated "it is too low", and the PCA explained, "it was OK, it has been 85% or so, so 83 is not horrible". At this time the resident requested her/his inhaler but the PCA voiced it was not time. The next day the resident requested her/his inhaler again and was denied. On 9/9/17 at approximately 2 PM, the PCA confirmed that the resident did not receive her/his scheduled inhaler or the as needed inhaler. The Medication Administration Record (MAR) for 4/1/17 through 4/4/17, evidences that the inhalers were never administered. There is no documented evidence that the facility Registered Nurse/Manager or the Nurse Practitioner was notified that the resident was having difficulty breathing or registered a low saturation level. Oxygen saturation is a measurement that identifies the percentage of oxygen in the blood. Values under 90% are considered low and result in hypoxia a sign of a problem to breathing or circulation that results in shortness of breath. (Lippincott Manuals of Nursing Practice, Wolters Kluwer Health/Lippincott, Williams and Wilkins p	R224		

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R224	Continued From page 12 370.) On 4/4/17 the Nurse Practitioner (NP), was scheduled for a monthly house call. On examination, the resident was diagnosed with an acute exacerbation of chronic obstructive pulmonary disease and an exacerbation of asthma. Resident #1 required the treatment of antibiotics, steroids and the addition of two (2) inhalers. On 9/18/17 at approximately 1:30 PM, the RN confirmed the above documentation is evident in the medical record and that it does not identify that the RN and/or the physician were notified.	R224		

BRADFORD OASIS
PLAN OF CORRECTION
OCTOBER 2017

R146
PCA did not respond appropriately to resident concerns and abnormal vital signs. Obtaining vital signs, normal ranges, and when to call for RN evaluation is part of orientation, but not documented separately. It will now be an individually documented item on the orientation list. Vital signs are also reinforced annually at staff meetings. RN/ADM will ensure this practice and documentation are maintained. Completed 10/8/2017.

R154
PCA did not appropriately notify RN for evaluation. RN should have been notified of the resident's distress at the time of occurrence. RN did not learn of this event until the next day. APRN became aware the next day as well at scheduled visit. Appropriate response to resident distress has been reinforced to staff and will continue to be an inservice topic. RN/ADM will ensure this practice is maintained. Completed 10/8/2017.

R155
Resident #1 had received informal permission to self-admin nitro. She proved herself to be responsible in reporting chest pain (a couple of years ago she was having night episodes of paroxysmal chest pain). Resident #2 had nitro in his possession. I had not given it to him nor given him permission to have it in his room. He is not capable of self- administration and reporting. He no longer has nitro in his possession. All residents who have nitro ordered have a supply in the med cart. RN will assess residents using facility form and will obtain PCP assessment as well as order for medication, dosing, reason for taking, self-administration. Residents will be responsible for obtaining approved prn medications Completed 10/8/2017.

R170
Answered above.

R171
Facility did not maintain scheduled AIMS assessment. Assessments have been updated and will continue as per policy. Of note, these are not new symptoms and all practitioners are well aware of chronic symptoms. RN/ADM will ensure this practice is maintained. Completed 10/8/2017.

R224
PCA did not respond appropriately to resident distress. Appropriate evaluation did not occur at the time of distress. PCA received a verbal reprimand 4/5/2017 from facility RNs. She chose to leave employment with Bradford Oasis. Resident's rights, appropriate staff response, and notification of RN have all been reinforced in staff meetings and continue to be an annual in-service topic. RN/ADM will ensure this is followed. Completed 10/8/2017.

Brenda Egbert, RN
10/10/17

BRADFORD OASIS

RESIDENT MEDICATION SELF ADMINISTRATION POLICY

Residents are allowed, by regulation, to keep over-the-counter prn (ad needed) medications in their rooms and to use them as needed. This includes tylenol, cough syrup, nitro, creams, and similar medications.

Residents are assessed at least annually by RN and PCP to ensure resident's ability to self-administer medications.

Resident knows the name of each prescribed medication.

Resident knows the purpose of each prescribed medication.

Resident knows the dose of each prescribed medication.

Resident knows when to take each dose of scheduled medication.

Resident knows side effects of each medication.

Resident is able and willing to tell staff when medications were taken, why taken, and the effect of the mediation. Staff will appropriately document all prn medication taken..

Resident is able to monitor medication supply and obtain refills when needed.

PCP has assessed and documented that resident may be responsible for self-administering medications and an order of approval has been obtained.

BRADFORD OASIS

RESIDENT SELF MEDICATION ASSESSMENT

Residents are assessed annually and as determined by RN or PCP

Resident knows the name of each prescribed medication: Yes No

Resident knows the purpose of each prescribed medication: Yes No

Resident knows the dose of each prescribed medication: Yes No

Resident knows when to take each dose of scheduled medication: Yes No

Resident knows side effects of each medication: Yes No

Resident is able to confirm medications taken or not taken as prescribed: Yes No

Resident is able to report if medications weren't taken and why: Yes No

Resident is able and willing to tell staff when prn meds are taken and why: Yes No

Resident is able to monitor medication supply and obtain refills when needed: Yes No

PCP has assessed and documented that resident may be responsible for self-administering medications and has written appropriate order: Yes No

RN:_____ Date:_____